North Carolina – Treatment Outcomes and Program Performance System (NC-TOPPS)
January 24, 2008 Advisory Committee Meeting Minutes

Attendees

Member/Representatives:

Kent Earnhardt	Consumer Representative
Sharon Garrett	Vision Behavioral Health Services, LLC
Robin Gravely	PBH – Piedmont Behavioral Healthcare
Jeff Matkins	Drug Free NC – Partnership
Connie Mele	Mecklenburg County Area Mental Health, Developmental Disabilities, Substance Abuse Authority
Pamela Moye	Guilford Consumer
Ann Paquette	Triumph/Saguaro Management
Christy Pelletier	Coastal Horizons
LisaCaitlin Perri	The Durham Center
Dave Peterson	Wake County Local Management Entity (LME)
Diocles Wells	Southeastern Center for Mental Health, Developmental Disabilities, & Substance Abuse

Guests:

Frank Barber	SouthLight, Inc.
Leatte Black	Eastpointe LME
Tammy Bonas	Wake County LME
Rose-Ann Bnyda	Cumberland LME
Connie Brown	Alamance-Caswell-Rockingham LME
Wes Caldwell	Easter Seals UCP
J.T. Cardwell	Drug Free NC – Partnership
Teresa Caudle	Crossroads LME
April Chambers	Cumberland LME
Margaret Clayton	Five County Mental Health Authority LME
John Coble	CenterPoint LME
Judy Cooper	Guilford Center LME
Wayne Dickinson	Cumberland County LME
Wes Early	Guilford Center LME
Joe Fortin	Guilford Center LME
Franklin Ingram	Dominion Ministries
Kim Keehn	East Carolina Behavioral Health LME
Angie Malan	Foothills LME
Paula Mauney	Southeastern Regional Mental Health, Developmental Disabilities and Substance Abuse Services LME
Sara McEwen	Governor's Institute
Derek Morgan	All Stars Group, LLC
Anna North	Eastpointe LME
Alison Parker	Innovation Research
Tammy Powers	Southeastern Regional Mental Health, Developmental Disabilities and Substance Abuse Services LME
Jan Sisk	Mecklenburg County Area Mental Health, Developmental Disabilities, Substance Abuse Authority LME
Janice Stroud	Citizen (Past Member)
Jay Taylor	Pathways Mental Health, Developmental Disabilities and Substance Abuse LME
Vince Wagner	Cumberland County LME
Bob Werstlein	Daymark Recovery Services

Staff:

Shealy Thompson	Quality Management, North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse (NC DMHDDSAS)
Becky Ebron	Quality Management, NC DMHDDSAS
Patrick Piggott	State Operated Services, NC DMHDDSAS
Jenny Wood	State Operated Services, NC DMHDDSAS
Karen Eller	North Carolina State University's Center for Urban Affairs and Community Services (NCSU CUACS)
Jaclyn Johnson	NCSU CUACS
Alexis Lockett	NCSU CUACS
Kathryn Long	NCSU CUACS
Mindy McNeely	NCSU CUACS
Marge Cawley	National Development and Research Institutes, Inc. (NDRI)
Gail Craddock	NDRI
Bob Hubbard	NDRI
Deena Murphy	NDRI
Lillian Robinson	NDRI

Meeting Convened at 10:00 a.m. with Self Introductions

October 25, 2007 Meeting Minutes Approved

Current Year Reports: Semi-Annual Template – G. Craddock

- SFY 2007 LME Semi-Annual matched reports will be finalized and posted next week to LME super user accounts. These reports match a consumer's Initial Interview to a 3-month Update Interview for mental health consumers and to either a 3-month Update or Episode Completion for substance abuse consumers. These reports capture Initial Interviews completed during the 2006 calendar year with a matched 3-month Update completed by the end of July 2007.
- LMEs can expect up to 5 reports: children with a mental health diagnosis, adolescents with a substance abuse or mental health diagnosis, and adults with a substance abuse or mental health diagnosis. The number of reports received depends upon the number of consumers for whom matches could be made as each report requires a minimum of 20 consumers to be generated.
- Reports providing information on Initial Interviews by LME or provider are also available, if the minimum of 20 consumers is met.
- These reports reflect the data based on the LME jurisdiction that existed at the time of data collection.
- Attendees were provided a graph that showed the sharp decline of Initial Interviews in June-Dec 2006 versus Jul-Dec 2005. Potential contributing factors identified were the March 2006 changes in service definitions and the impact of particular LMEs reorganizing.

Improving Overall Use and Compliance – M. McNeely, S. Thompson, & Attendee Breakout Groups

- Four issues dominated the discussion of use and compliance: (1) decreasing the length and complexity of the NC-TOPPS instrument, (2) changing the interview timeframes, (3) decreasing confusion over which consumers are required to have NC-TOPPS interviews based upon the consumer's funding source, and (4) modifying the episode of care definition. Breakout groups of attendees discussed episode of care and the focus groups. Their thoughts are also included in the discussion below.
- Decreasing the length and complexity of the NC-TOPPS instrument: the ultimate goal is a 25-33% reduction of the tool.

- Attendees were asked to sign up for focus groups to be tentatively held in February 2008 to determine potential items for elimination. Focus groups members will receive guidance by Division identification of those items needed for Division/LME purposes and funding source requirements. The NC-TOPPS management team will ascertain items that must be kept, those that can be dropped because they are not answered or not utilized. After this management team review, input will be obtained from other stakeholders.
- LMEs were asked to host focus groups, at least 1 per region and to facilitate participation of various parties: consumers and family members, providers and LME staff. LMEs were asked to identify providers to be targeted for participation.
- A request was made to consider inclusion of other users of NC-TOPPS like methadone and maternal care groups.
- Some members voiced concern about the swift proceeding of this project to revise the tool. Members were reassured that the approach would be strategic and project leaders would take heed of lessons learned from the COI experience.
- The plan is to have NC-TOPPS Interview revisions completed by May 1 so the programming can be completed for implementation on July 1, 2008.
- From the Advisory breakout groups the following suggestions were provided on framing the focus groups:
  - For consumers simplify the discussion to specific items.
  - Length should be no more than three hours with a 15 minute break.
  - Groups should have approximately 10 participants.
  - Each of the four regions of the state should have two days with two sessions per day.
  - Each group should receive homework in advance so they come to the meeting prepared.

❖ Changing the Interview timeframes:
- Presently an interview is requested for all consumers at the beginning of treatment, in treatment at 3 months, 6 months, annually and every 6 months thereafter while in treatment and at discharge.
- Alternatives being discussed include:
  - Consumers with a substance abuse diagnosis would be interviewed at the start of treatment, 3 months into treatment, and at discharge.
  - Consumers with a mental health diagnosis would be interviewed at the start of treatment, 6 months into treatment, annually thereafter while in treatment and at discharge from treatment services.
  - Consumers in methadone treatment would be interviewed at the start of treatment, 3 months into treatment, annually thereafter in treatment, and at discharge.
  - Consumers with a co-occurring diagnosis would remain on the present schedule.
- Attendees commented that differing schedules may be tough for clinicians to remember.
- It was also noted that the mental health field is trying to move towards discharging by the sixth month of treatment.
- The question of continued recovery was also raised.

❖ Decreasing confusion over which consumers are required to complete NC-TOPPS interviews based on the consumer's funding source. It was stated that those providing services often are not knowledgeable of the funding source of their consumers.
- Currently IPRS consumers and Medicaid enhanced benefits consumers are required to participate in NC-TOPPS.
- The Division is proposing to not require NC-TOPPS participation of mental health consumers who receive only medication management or outpatient services. Substance abuse consumers funded under IPRS who receive outpatient services will still be required to participate in NC-TOPPS.
- Attendees also suggested allowing for NC-TOPPS to be completed on all consumers an

agency provides services to. This can be done now. Providers desiring to conduct NC-TOPPS Interviews on all of their consumers need to contact Kathryn Long at the Center for Urban Affairs who can help them set-up how to do this.

- Discussion ensued over the difficulty providers sometimes have in timely getting an LME consumer record number. For those providers who experience long delays in acquiring a consumer record number from the LME, it was suggested to enter a fake number to begin the interview but only send the interview once the actual number is received. This allows for the interview to be opened on the date the consumer was seen since it is not possible to backdate an interview.
- It was also suggested that a list of the service codes under Medicaid and IPRS of those consumers for whom NC-TOPPS is required be provided.
- Desire to have information on consumers who drop out of service or who disappear also needs to be part of the focus group discussion. Data on these consumers need to be analyzed.

❖ Modifying the episode of care to follow the consumer:

- The Division is suggesting that a single episode of care for NC-TOPPS begin when a consumer enters treatment and ends when the consumer leaves even if the consumer moves from one provider to another or moves to different levels of care as long as this is done within one LME. Currently, if a consumer moves from one provider to another or changes level of care even within the same LME, a Transfer/Episode Completion is expected. Then when the consumer begins at a new provider, an Initial Interview is required. This inflates the number of Initial Interviews and discharges. More importantly, it is burdensome for the consumer.
- Currently the system has a great deal of movement. The goal under this new definition is to more realistically capture activity of a single episode of care for a consumer. The change proposed would follow the consumer and there would no longer be several episodes of care but a single episode of care.
- Barriers identified by attendees include:
  - How will LMEs know when there is a clinician change or consumers choose a different provider?
  - What happens when a consumer leaves, but does not reenter treatment in a timely manner?
  - How can LMEs learn about the consumers that Medicaid only providers serve?
  - Which provider can take credit/responsibility for consumer outcomes?
  - How can reports be done for a particular time in care for a specific provider?
  - How can we insure that needed consents for redisclosing information are done? For example, consumers may not remember all of their providers.
- Possible solutions:
  - Get a list of all authorized consumer services from Value Options. You can get this for mental health consumers, but not substance abuse consumers.
  - Division staff stated that Medicaid providers should be sending a PCP on every consumer that has one. This should be taking place at the start of service and at any point that the PCP changes.
  - LMEs have NC-TOPPS, claims and authorization data. The different sections within the LME capturing this information need to talk to each other and coordinate a process to know who is being served.
  - Reports can be provided for providers by time periods. That is, a report can be produced for the provider who served the consumer between the Initial and the 3-month Update and so on. If two providers serve the consumer during this time period then the one who conducted the 3-month Update will get the report. These reports that display aggregate data can be shared among participating providers.

- An example Coordination of Benefits authorization example is provided in the Guidelines.

Improving Use and Compliance at the LME level – J. Taylor

- A handout was provided listing tried and considered efforts by the NC-TOPPS Submission Improvement Workgroup, a subgroup of the NC Council's QI Forum.
- Examples of tried efforts included:
  - Providing training and technical assistance
  - Frequent reminders (feedback)
  - Linking the NC-TOPPS interview with other topics (PCPs, accreditation, and evaluations, etc.)
  - Utilizing plans of correction when providers fall below a 90% completion rate.
- It was suggested that LMEs also use endorsement and payment as leverage for improving compliance.
- It was noted that not all actions will work for each LME. They have found that what works in one LME may not work in another.

Building Evaluation Capacity Follow-up – D. Murphy

- At the previous advisory committee meeting, attendees participated in a conversation about "Building evaluation capacity in North Carolina: Using NC-TOPPS data." (Please see October 25, 2007 Advisory Minutes for this presentation.) The aim was to start building interest and capacity within the substance abuse and mental health services treatment system to inspire improved submission and reporting of NC-TOPPS data. Five breakout groups comprised of providers, LMEs, consumers, quality management, and researchers/evaluators were formed. The following bullets summarize the feedback from the October 25 breakout groups.
- *Other than lack of staff, time, and funding, what three issues does your group believe are the most important barriers to using evaluation as a learning tool?*
  - Providers felt that the key issues that acted as the most important barriers to using evaluation as a learning tool were:
    - Staff lack knowledge of evaluation process
    - Staff resistance to data collection
    - Overly complex/time consuming tools to collect data/information
    - Computer hardware/software problems
    - Conflicts with work or intervention preference, i.e. therapy
    - Not enough evaluation expertise to conduct evaluation
    - Not enough training on how to use data, information, or evaluation tools
    - Data collection or data management issues
    - Lack of available tools to collect data/information
    - Excessive reporting requirements
    - Lack of NC-TOPPS as an ongoing integrated process essential to authorization
  - LMEs felt that the key issues that acted as the most important barriers to using evaluation as a learning tool were:
    - Resistance to data collection by providers
    - Submission of data (or lack thereof)
    - Having a convenient way to get and analyze the data
    - Need to tie compliance to authorizations or funding (Medicaid and IPRS)
  - Consumers felt that the key issue that acted as the most important barrier to using evaluation as a learning tool was:
    - Stigma attached to consumers makes it hard to get voice heard; lack of confidence in trusting consumers to understand their own disease and perceptions of that disease and treatment progress/process.

- Quality management people felt that the key issues that acted as the most important barriers to using evaluation as a learning tool were:
  - Staff lack knowledge of evaluation process and how data drives our system
  - Staff resistance to data collection
  - Limited communication about reports or results within organization
  - Lack of incentives by funders (e.g., rewards, support for process, recognition)
- Researchers/evaluators felt that the key issues that acted as the most important barriers to using evaluation as a learning tool were:
  - Staff resistance to data collection
  - Data collection or data management issues
  - Clinicians are not research minded; more into helping the consumer, not filling out another form

❖ *Which types of evaluation information, processes or activities would be most useful to your group?*

- Providers felt that the following types of evaluation information, processes or activities would be most useful to their group:
  - Planning and designing an evaluation plan that would answer your questions about program or organizational effectiveness
  - Collecting (or finding) outcome data relevant to questions about effectiveness
  - Reporting and defending your conclusions about your programs
  - Feedback by diagnoses on treatment programs
- LMEs felt that the following types of evaluation information, processes or activities would be most useful to their group:
  - Strategies for obtaining stakeholder buy-in regarding participation in evaluation
  - Understanding how to use data to identify the most at-risk clients for care coordination, etc
- Consumers felt that the following types of evaluation information, processes or activities would be most useful to their group:
  - Trained consumer evaluators
  - Keeping evaluation simple and not over-professionalizing the process
  - Including consumers at each step of the evaluation process
- Quality management people felt that the following types of evaluation information, processes or activities would be most useful to their group:
  - Techniques for coming to agreement about the primary goals and outcomes of your program(s) (e.g., logic models)
  - Strategies for obtaining stakeholder buy-in regarding participation in evaluation
  - Collecting monitoring data to determine whether your operations or programs are proceeding as planned
  - Techniques for sharing evaluation results with different audiences
- Researchers/evaluators felt that the following types of evaluation information, processes or activities would be most useful to their group:
  - How to identify and select appropriate indicators of important outcomes
  - Analyzing and understanding the data you have collected (or have available)
  - Reporting and defending your conclusions about your programs

❖ *Which resources would be most useful to your group?*

- Providers felt that the following types of resources would be most useful to their group:
  - Technical assistance (e.g., help from an outside agency) to design and maintain an evaluation system
  - Agency specific training on how to use evaluation in your organization

  - Organized meetings and collaborations with similar nonprofits around evaluation issues (e.g., best use of time, staff, funds)
  - An on-line searchable database on literature surrounding current evaluation practices
  - Centralized internal monitoring system to ensure staff follow through with follow-up NC-TOPPS and initial; essential medical record that has built-in logic that will not allow staff to proceed with services until NC-TOPPS are done
- Consumers felt that the following types of resources would be most useful to their group:
  - Consumer-specific training on how to use evaluation for advocacy
  - Consumer technical assistance centers such as at the University of MO, St. Louis (Jean Campbell's work)
- Quality management people felt that the following types of resources would be most useful to their group:
  - Technical assistance (e.g., help from an outside agency) to design and maintain an evaluation system
  - Organization-wide training on why and how to use evaluation to facilitate organizational learning
- Researchers/evaluators felt that the following types of resources would be most useful to their group:
  - Agency specific training on how to use evaluation in your organization
  - Organization-wide training on why and how to use evaluation to facilitate organizational learning
  - Working with clinicians to gain buy-in for data collection; explaining why this is important and how it will help them

❖ *Making evaluation tools like NC-TOPPS more useful… Other than external accountability, could you provide one or two examples of how your group has used (or could use) NC-TOPPS?*

- Providers have used NC-TOPPS for quality assurance, accreditation, to assess treatment program outcomes, look at different groups, and to market evidence based practices.
- LMEs could use NC-TOPPS for grant writing or going to counties for funding.
- Consumers have used NC-TOPPS at a presentation. It is specific enough to understand and can be used for advocacy.
- Quality management people have used/could use NC-TOPPS as part of a QI project for providers, to report gaps in services/outcomes/service needs, to assess evidence based practices, and to look at MST.
- Researchers/evaluators have used/could use NC-TOPPS for community needs assessment, to look at barriers to treatment (transportation/housing), to look at whether providers using evidence based practices are doing better than those who are not.

❖ *What issues would your group like to see included in on-line training related to using NC-TOPPS as a learning tool?*

- Providers would like to see more issues around question interpretation and also more integration with providers' electronic medical record system; IT training
- LMEs would like to see more training on interrater reliability (to understand how well/consistently the questions are being interpreted)
- Consumers would like training on how to use data quickly, how to graph data for effective presentation.
- Researchers/evaluators would like to see case studies of how people have used NC-TOPPS data to improve, along with hyperlink questions (frequently asked questions).

❖ *People who agreed to be included in a future "workgroup" connected to using NC-TOPPS for organizational learning:*

- Providers interested in ongoing dialogue are Tania Smith, Family Intervention and Prevention; Jeannie King, The Mentor Network; and Bob Werstlein, Daymark Recovery Services.
- LMEs interested in dialogue are Beth Nelson, Wake LME and Connie Brown, Alamance LME.
- Consumers interested in dialogue are Kent Earnhardt.
- Quality management people interested in dialogue are Dave Peterson, Wake LME; Lisa Caitlin Perri, The Durham Center; and Paula Mauney, Southeastern Regional LME.

NC-TOPPS Umbrella Update: MH/SA; ADATC; TASC; DD – M. Cawley

- As noted at the beginning of this meeting the mental health and substance abuse NC-TOPPS tool is undergoing a major revision for SFY 2009. ADATC is in full implementation but still is in a pilot mode making changes in its tool based upon reporting and data analysis. TASC is fully implemented. As noted in prior meetings, there is no action to incorporate DD under NC-TOPPS.

Clinician Query Feedback – M. McNeely

- The product has been delayed, but conversation and work continues with the contractor. Feedback from Advisory Committee members has been garnered and incorporated into the design of the Clinician Query. No specific date of delivery has been established, but hoping to have in the Spring.

NC-TOPPS Snapshot Update – M. Cawley

- This publication is a proposed monthly one-pager to be posted on the NC-TOPPS website. Each issue of this publication will highlight a specific topic. The first edition is currently going through the Division approval process.

December Training Update and Feedback – J. Johnson

- Three basic NC-TOPPS trainings were held: one in Asheville and two in Raleigh.

Other

- None

Wrap Up and Adjournment

- Meeting adjourned at 2:30 p.m.

Please contact Marge Cawley at cawley@ndri-nc.org for a copy of the PowerPoint presentations and/or handouts given during the meeting.